



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DR AHMED KHALIFA
1415 SOUTH HWY 6 SUITE 400D
SUGARLAND TX 77478

Respondent Name

HARRIS COUNTY

Carrier's Austin Representative Box

Box Number 21

MFDR Tracking Number

M4-11-1807-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Pre-authorized. Fee Guideline."

Amount in Dispute: \$108.79

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor is seeking additional reimbursement for date of service August 17, 2010 in the amount of \$108.79." "The reimbursement at issue in the current request is for cervical medical branch radiofrequency thermocoagulation performed by Dr.Khalifa at two levels. The Carrier preauthorized this procedure at no more than two levels in accordance with the Official Disability Guidelines. The Carrier properly reimbursed the provider to for the preauthorized procedure in the amount of \$444.87 for the first level and \$109.15 for the second level. In reference to CPT code 64627, the Carrier reimbursed the provider for the procedure that was performed to the right side only at the second level of the cervical spine. One unit only at two levels were preauthorized and reimbursed. All amounts have been paid in accordance with the Medical Fee Guidelines."

Response Submitted by: Harris County, Thornton, Biechlin, Segrato, Reynolds & Guerra, L.C., 912 S. Capital of Texas Hwy., Suite 300, Austin, TX 78746-5242

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 17, 2010	CPT Code 64627 (X3)	\$108.79	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated September 14, 2010

- W1A-Workers Compensation State Fee Schedule Adjustment*Reimbursement per Rule 134.203/134.204. prior to March 1, 2008, Rule 134.202.

Explanation of benefits dated October 5, 2010

- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Did the requestor support billing of the additional levels of CPT code 64627?
2. Was the payment issued for CPT code 64627 in accordance with 28 Texas Administrative Code §134.203?
3. Is the requestor entitled to reimbursement?

Findings

1. On August 9, 2010, the respondent's representative, Argus Services Corporation, gave preauthorization approval for "Cervical Medial Branch Radiofrequency Thermocoagulation (RFTC) at no more than two levels per ODG criteria."

A review of the operative report indicates that the claimant underwent "Radio-frequency facet neurectomy with destruction of nerves, cervical area. Levels: Right C3-4 and C5-6."

Based upon the submitted medical bill and explanation of benefits, the requestor billed the respondent for four levels, and was paid for the two preauthorized levels under CPT codes 64626 and 64627.

The Division can not recommend payment for the additional levels billed under CPT code 64627.

2. CPT code 64627 is defined as "Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, each additional level (List separately in addition to code for primary procedure)."

Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007."

COMMISSIONER'S BULLETIN #B-0048-09 states "The conversion factor of \$68.19 applies to Surgery when performed in a facility setting."

Review of Box 32 on the CMS-1500 the services were rendered in zip code 77027, which is located in Harris County.

The MAR for CPT code 64627 in Harris County is \$109.15 (WC Conv 68.19/Medicare Conversion 36.8729 X \$59.02 participating amount). CPT code 64627 is exempt from the multiple procedure rule discounting; therefore, a reduction to the MAR will not be taken. The respondent paid \$109.15.

3. The difference between the MAR of \$109.15 and amount paid of \$109.15 is \$0.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	<u>2/29/2012</u>
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.